STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

Docket No. 2010-52370 HHS
[redacted], Case No. [redacted]

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.,* upon the Appellant's request for a hearing.

After due notice, a hearing was held [redacted]. [redacted], appeared on the Appellant's behalf. [redacted], represented the Department. [redacted], and [redacted], appeared as Department witnesses.

ISSUE

Did the Department properly terminate Home Help Services (HHS) payments to the Appellant?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. The Appellant is a [redacted] Medicaid beneficiary who was receiving Home Help Services.

2. In [redacted], the Department received documentation that the Appellant has been diagnosed with schizophrenia. (Exhibit 1, page 16)

3. On [redacted], the Social Worker completed a home visit as part of an annual comprehensive review of the Appellant's HHS case. A request for increased HHS services was made. The Appellant's HHS provider had two DHS 54-A Medical Needs Forms to submit, but the Social Worker noted that neither was valid. The Appellant's provider also did not have a current picture ID. (Social Worker Testimony and Exhibit 1, page 12)

4. Department policy requires verification of medical need by a Medicaid enrolled physician, nurse practitioner, occupational therapist or physical therapist. Adult Services Manual (ASM) 363, 9-1-2008, page 9 of 24. (Exhibit 1, page 26)

5. On [redacted], the Department sent an Advance Negative Action Notice to the Appellant indicating his HHS payments would be suspended effective [redacted], because the provider must have a valid ID with the correct address. (Exhibit 1, pages 7-9)

6. On [redacted], the Social Worker followed up with the Appellant's medical providers for verification of medical need and with the Appellant's HHS provider for an updated ID. (Exhibit 1, page 11)

7. The Department has not been able to obtain a current DHS 54-A Medical Needs Form completed by a Medicaid enrolled physician, nurse practitioner, occupational therapist or physical therapist for the Appellant's HHS case. (Social Worker Testimony and Exhibit 1, pages 11-12, 18 and 20)

8. On [redacted], the Department sent an Advance Negative Action Notice to the Appellant indicating his HHS payments would terminate effective [redacted], because there was no valid DHS 54-A or ID for the Appellant's provider. (Exhibit 1, pages 4-6 and 10)

9. The Appellant requested a formal, administrative hearing contesting the termination on [redacted].

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

Home Help Services (HHS) are provided to enable functionally limited individuals to live independently and receive care in the least restrictive, preferred settings. These activities must be certified by a physician and may be provided by individuals or by private or public agencies.

The Adult Services Manual (ASM 363, 9-1-08), addresses the issues of assessments, provider identity verification, and medical need:

COMPREHENSIVE ASSESSMENT

The Adult Services Comprehensive Assessment (FIA-324) is the primary tool for determining need for services. The comprehensive assessment will be completed on all open cases, whether a home help payment will be made or not. ASCAP, the automated workload management system provides the format for the comprehensive assessment and all information will be entered on the computer program.

Requirements for the comprehensive assessment include, but are not limited to:

- A comprehensive assessment will be completed on all new cases.
- A face-to-face contact is required with the client in his/her place of residence.
- An interview must be conducted with the caregiver, if applicable.
- Observe a copy of the client's social security card.
- Observe a picture I.D. of the caregiver, if applicable.
- The assessment must be updated as often as necessary, but minimally at the six-month review and annual redetermination.
- A release of information must be obtained when requesting documentation from confidential sources and/or sharing information from the department record.
- Follow specialized rules of confidentiality when ILS cases have companion APS cases.

Functional Assessment

The **Functional Assessment** module of the **ASCAP** comprehensive assessment is the basis for service planning and for the HHS payment.

Conduct a functional assessment to determine the client's ability to perform the following activities:

Activities of Daily Living (ADL)

- Eating
- Toileting
- Bathing

- Grooming
- Dressing
- Transferring
- Mobility

Instrumental Activities of Daily Living (IADL)

- Taking Medication
- Meal Preparation and Cleanup
- Shopping
- Laundry
- Light Housework

Functional Scale ADL's and IADL's are assessed according to the following five-point scale:

1. Independent
   Performs the activity safely with no human assistance.
2. Verbal Assistance
   Performs the activity with verbal assistance such as reminding, guiding or encouraging.
3. Some Human Assistance
   Performs the activity with some direct physical assistance and/or assistive technology.
4. Much Human Assistance
   Performs the activity with a great deal of human assistance and/or assistive technology.
5. Dependent
   Does not perform the activity even with human assistance and/or assistive technology.

Note: HHS payments may only be authorized for needs assessed at the 3 level or greater.

Time and Task

The worker will allocate time for each task assessed a rank of 3 or higher, based on interviews with the client and provider, observation of the client's abilities and use of the reasonable time schedule (RTS) as a guide. The RTS can be found in **ASCAP** under the **Payment** module, Time and Task screen.

IADL Maximum Allowable Hours

There are monthly maximum hour limits on all IADLs except medication. The limits are as follows:

- 5 hours/month for shopping
- 6 hours/month for light housework
- 7 hours/month for laundry
- 25 hours/month for meal preparation

These are maximums; as always, if the client needs fewer hours, that is what must be authorized. Hours should continue to be prorated in shared living arrangements.

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REVIEWS

ILS cases must be reviewed every six months. A face-to-face contact is required with the client, in the home. If applicable, the interview must also include the caregiver.

Six Month Review

Requirements for the review contact must include:

- A review of the current comprehensive assessment and service plan.
- A reevaluation of the client's Medicaid eligibility, if home help services are being paid.
- Follow-up collateral contacts with significant others to assess their role in the case plan.
- Review of client satisfaction with the delivery of planned services.

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Annual Redetermination

Procedures and case documentation for the annual review are the same as the six month review, with the following additions:

Requirements

- A reevaluation of the client's Medicaid eligibility, if home help services are being paid.
- A new medical needs (DHS-54A) certification, if home help services are being paid.
  Note: The medical needs form for SSI recipients will **only** be required at the initial opening and is no longer required in the redetermination process. All other Medicaid recipients will need to have a DHS-54A completed at the initial opening and then annually thereafter.
- A face-to-face meeting with the care provider, if applicable. This meeting may take place in the office, if appropriate.

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Necessity For Service
The adult services worker is responsible for determining the necessity and level of need for HHS based on:

- Client choice.
- A complete comprehensive assessment and determination of the client's need for personal care services.
- Verification of the client's medical need by a Medicaid enrolled medical professional. The client is responsible for obtaining the medical certification of need. The Medicaid provider identification number must be entered on the form by the medical provider. The Medical Needs form must be signed and dated by one of the following medical professionals:
  - Physician.
  - Nurse practitioner.
  - Occupational therapist.
  - Physical therapist.

Exception: DCH will accept a DHS-54A completed by a VA physician or the VA medical form in lieu of the medical needs form.

The medical professional certifies that the client's need for service is related to an existing medical condition. The medical professional does not prescribe or authorize personal care services.

> If the medical needs form has not been returned, the adult services worker should follow-up with the client and/or medical professional.
>
> If the case is closed and reopened within 90 days with no changes in the client's condition, a new DHS-54A is not necessary.
>
> Do **not** authorize HHS prior to the date of the medical professional signature on the DHS-54A.
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> Adult Services Manual (ASM 363) 9-1-2008, Pages 2-9 of 24

The Appellant's case was transferred to a new worker in [redacted]. (Exhibit 1, page 10) On [redacted], the worker completed a home visit as part of a comprehensive assessment for the annual redetermination. (Exhibit 1, page 12) The above cited policy requires the Department worker to observe a picture ID of the HHS provider. It is uncontested that at the time of the [redacted], home visit, the Appellant's HHS provider's ID was expired. The Appellant's HHS provider testified that he was unable to afford a new ID at that time. The Social Worker testified that the Appellant was advised that he could choose to have a different HHS provider enrolled to avoid the termination of his HHS case. The Appellant did not choose to have a different HHS provider. A current ID for the Appellant's HHS provider was not shown to the Department until the [redacted], hearing date, and this ID was obtained only a few days earlier. (Social Worker and HHS Provider Testimony) Accordingly, the Department was not able to observe a current picture ID at the home visit, at the time the suspension notice was issued or when the termination notice was issued.

In addition to not being able to observe a current ID, the termination of the Appellant's HHS case was also based on not being able to obtain a valid DHS 54-A Medical Needs Form. Under Department policy, a new DHS 54-A is not required at annual redetermination for SSI recipients. The Appellant was an SSI recipient at the time of the [redacted], home visit. (Social Worker Testimony) However, the Social Worker explained that a new DHS 54-A Medical Needs Form was needed to support the request for an increase in HHS services. Neither DHS 54-A provided at the [redacted], home visit was valid. The first was not correctly completed as it did not have an NPI number for a Medicaid enrolled provider or proper signatures. The second was completed by a podiatrist. (Exhibit 1, page 12) The above cited policy requires verification of medical need by a Medicaid enrolled physician, nurse practitioner, occupational therapist or physical therapist and requires the provider to enter their Medicaid provider identification number on the DHS 54-A Medical Needs Form.

The Adult Services Manual addresses the fact that the Department must have verification of medical need for assistance from a Medicaid enrolled physician, nurse practitioner, occupational therapist, or physical therapist in order to authorize Home Help Services. On [redacted], the Social Worker followed up with the Appellant's medical providers from the invalid DHS 54-A Medical Needs forms provided at the home visit to try to obtain verification of the Appellant's need for increased HHS services. The visiting physician's office reported that they had not completed the DHS 54-A Medical Needs Form the Appellant's provider gave to the worker. While this doctor's office did indicate some services may be warranted, they did not fax the requested verification of this on valid DHS 54-A Medical Needs Form to the Department. The provider's office from the second DHS 54A Medical Needs form confirmed that the doctor is a podiatrist and is not one of the four types of medical professionals listed in the Department policy that can certify medical need by completing this form. (Exhibit 1, page 11) As of the [redacted], hearing date, the Department has not received a current, valid, DHS 54-A Medical Needs Form for the Appellant. (Social Worker Testimony)

The Department properly suspended then terminated the Appellant's Home Help Services application based on the information available at that time. If the Appellant is able to obtain different documentation from a Medicaid enrolled physician, nurse practitioner, occupational therapist or physical therapist, certifying that he has a medical need for services, he can always re-apply for Home Help Services.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds the Department has properly terminated Home Help Services payments for the Appellant based on the available information.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Colleen Lack
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

[redacted]
Docket No. 2010-52370 HHS
Decision and Order

[redacted]

Date Mailed: 11/24/2010

***** NOTICE *****

The State Office of Administrative Hearings and Rules may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The State Office of Administrative Hearings and Rules will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.